

Ohio Medicaid Health Home Program

1

**HEALTH HOME
INFORMATIONAL FORUM
WRAP-UP WEBINAR**

**JUNE 22, 2012
9:00 AM – 10:30 AM**

HEALTH HOME INFORMATIONAL WRAP-UP WEBINAR AGENDA

- **Target Population**
- **Interface between health home and other services and programs**
- **Billing & Reimbursement**
- **Regions**
- **General Updates**
- **Next Steps**

Q & A: Target Population

3



Does a provider have to serve all age groups/populations?

4

- **Providers must have the capacity to serve existing clients with SPMI and be able to accept new referrals**
 - The Ohio health home model does not include a pilot or phase-in period at the provider level
 - Providers should focus on clients with SPMI currently receiving CPST to assure a seamless transition
 - Providers do not need to change the age group they serve (e.g. youth, adult) or populations (e.g. forensic, homeless) to become a health home

Is the health home service voluntary?

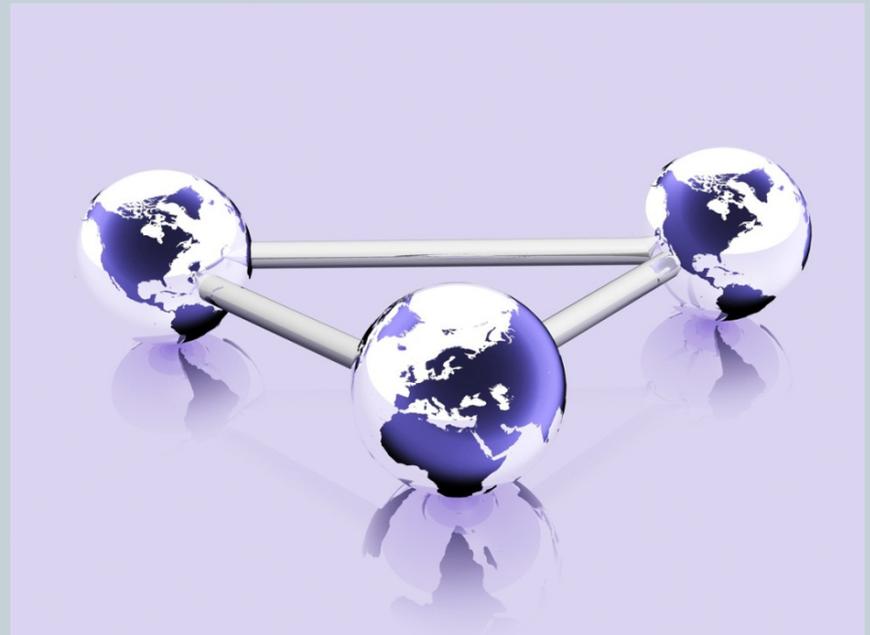
5

- Consistent with other Medicaid services, client choice will determine whether a client participates
 - The state cannot force a client into any service nor prevent them from participating
- Health home is a service delivery model with multiple service components that may benefit each individual client depending on where they are in their recovery
- State will send a high level communication but also encourage providers to educate SPMI clients and their families/caregivers

How does a health home interface with other services and/or programs?

6

- ICDS
- CPST
- DODD
Targeted Case Management
- Treatment Foster Care
- ACT/IHBS
- Peer Support
- AoD Treatment Services



How do health homes interface with ICDS* for the Medicare & Medicaid Dual-Eligible Population?

7

- **Payment for all services, including the Health Home, will be through the ICDS**
- **Payment by the ICDS will be at the established fee-for-service rate**
- **Consumers may receive care coordination through Health Homes for the life of the ICDS demonstration**
- **Contract and other ICDS requirements and/or details are currently being developed**

* Integrated Care Delivery System

Can a client receive CPST from another provider while receiving health home services?

8

- **All CPST activities are now incorporated in the health home service and delivery model**
- **If a client is enrolled in a health home, activities formerly provided under CPST are included in the health home and are no longer separately reimbursable for that client**
 - In rare instances, when a client chooses to not participate in health homes, they can continue to receive CPST services
- **CPST can continue**
 - to be provided to clients who do not meet SPMI criteria
 - to be provided to clients with SPMI who choose to not participate in the health home via inclusion of a modifier code
- **State will track and monitor the use of CPST in these circumstances**
- **Current CPST limits will remain in place**

How do health home services interface with DODD targeted case management (TCM)?

9

- A developmental disability diagnosis without the presence of a SPMI diagnosis does not qualify a person for health home service
- Targeted case manager authorizes DODD waiver services
- Recommendation is that CBHC health home providers continue to work with DODD TCM providers to assure a client does not lose their TCM and therefore waiver services
- Goal is to assure continuity of care and that the client's needs are met

Can children in foster care participate in a health home?

10

- **Children in foster care can receive health home service if they meet the SED criteria and the client/parent/guardian chooses the service**
- **ODMH encourages therapeutic foster care providers to assess whether or not they could potentially meet health home provider requirements**

How do health home services interface with ACT/IHBT in the future?

11

- **Initial thinking was to establish two rates each for ACT and IHBT**
 - ACT/IHBT rate for clients not receiving health home service
 - ACT/IHBT rate for clients receiving health home service
- **Subsequent recommendation, based on feedback at the informational sessions, is that when a client no longer meets the IHBT or ACT eligibility criteria then the client will be transitioned to the health home team**
- **The state will continue to look at the relationship between ACT/IHBT and health homes as ACT/IHBT services and related Medicaid policies are being developed**

How do health home services interface with Peer Support?

12

- **There are several ways in which Peer Support can be included in the health home:**
 - Peers can be included as a health home team member
 - ✦ Qualified Health Home Specialist
 - The service component descriptions include several activities that can be performed by peer support specialists
 - ✦ Individual and family support, health promotion
- **The state will continue to look at the relationship between Peer Support and health homes as Peer Support services and related Medicaid policies are being developed**
 - It will be important to distinguish how Peer Support is different from CPST

How do health home services interface with AoD Services and/or Providers?

13

- **There are several ways in which AoD services and/or providers are included in the health home**
 - Many CBHCs who are eligible to become health homes are also certified by ODADAS
 - The required health home team can include members with AoD treatment expertise
 - Health Home outcome requirements include the goal to Reduce Substance Abuse
 - Health Homes must coordinate care with all specialty providers, including those who are providing AOD treatment services
 - AoD treatment providers shall be part of the health home's network of providers

Q & A: Health Home Billing & Reimbursement

14



When and/or how often will the monthly case rate be reviewed/updated?

15

- **Providers' monthly case rates will be reviewed annually to determine whether or not it is necessary to rebase the case rate(s)**
 - This review will be based on all providers' actual costs for the prior year
- **Cost based case rate methodology is in effect until sufficient baseline information is collected to determine a performance component for setting subsequent rates**
- **CMS must approve an approach to transition from the cost based methodology**

Will the state reimburse for upfront start-up costs?

16

- **No**
- **Administrative costs should be completed in accordance with ODMH UCR rules**

Q & A: Health Home Regions

17



When will the health home regions be chosen?

18

- **Significant interest and response to the ODMH request for LOI was received**
- **LOIs are being reviewed to determine local readiness**
 - When CBHCs are fully able to meet requirements
 - Local capacity across providers to meet identified need within a region
- **ODMH will announce the regions on or before July 1, 2012**

Other General Updates

19

- **Care Manager Aide title has been revised to Qualified Health Home Specialist**
- **National Accreditation to demonstrate BH/PH integration will be required at the next scheduled survey**
 - COA BH/PH accreditation is also acceptable
 - NCQA PCMH recognition or equivalent will still be required in 18 months as applicable

Other General updates

20

- **Health home modes of service delivery may be**
 - delivered to the beneficiary and may include other individuals who will assist in the beneficiary's treatment;
 - be face-to-face, by telephone, and/or by video conferencing;
 - individual, family or group format; and
 - not site-specific and the health home services should be provided in locations and settings that meet the needs of the health home beneficiary.
- **ODMH has released a draft certification rule as well as other rules which have been amended to support the inclusion of health homes in the ODMH standards**
 - The rules will go through the normal public process and we have received comments through the clearance process which we will be reviewing

Next steps

21

- **June**

- Submit official SPA
- ODMH will post rules for comments and file with JCARR
- ODJFS will put rules into clearance and subsequently file with JCARR
- ODMH/ODJFS will finalize business requirements for client utilization profile in conjunction with stakeholder feedback

- **July**

- ODMH will announce regional implementation schedule
- ODMH will post Provider Application
- Providers in selected regions can begin to submit applications
- ODMH will continue to work with advocacy organizations to engage their assistance to educate consumers, families and others

Next Steps, continued

22

- **August**

- Providers will be notified of application status in initial regions
- ODMH will work with providers on implementation details such as identifying consumers, training on how to report quality measures, sharing of the consumer utilization profile, etc.

- **September**

- Identify clients participating in health home
- Receive CMS approval for health home for SPMI

- **October**

- State shares Client utilization profile
- Submit claims to ODJFS for S0281

Where can additional resources be found?

23

- **ODMH Health Home Website**
 - <http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/medicaid/health-home-committees.shtml>
- **ODMH Health Homes mailbox**
 - E-mail to: healthhomes@mh.ohio.gov

More Questions?

24

